Medical Assistance Provider Bulletin

Attention: All Title XIX Certified Rehabilitation Agencies, Occupational Therapists, Physical Therapists, Speech Pathologists and Speech/Hearing Clinics

Subject: New "OI" Codes and Claim Form Instructions; Noncovered versus Covered Services

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Department of Health and Social Services, Division of Health,
Bureau of Health Care Financing, P.O. Box 309, Madison, Wisconsin 53701

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I. *INTRODUCTION*

This Medical Assistance Provider Bulletin (MAPB) provides important information on changes in the Wisconsin Medical Assistance Program's (WMAP) billing requirements on the HCFA 1500 claim form. ***It is imperative that providers review this information carefully and share it with billing staff.***

II. *REVISED HCFA 1500 CLAIM FORM COMPLETION INSTRUCTIONS*

Revised HCFA 1500 claim form instructions are included as Attachment 1 of this MAPB. These instructions are effective with claims received by EDS on or after January 4, 1993. All claims, including resubmission of any previously denied claims, received by EDS on or after January 4, 1993, must be submitted according to the instructions included with this MAPB. This applies to all paper claims, electronic claims, and crossover claims for coinsurance and deductible for Medicare Part B allowed charges.

All claims received by EDS prior to January 4, 1993, must be submitted according to the claim form completion instructions in MAPB-092-024-D. Please retain these instructions to ensure the accurate submission of claims.

Important Note: Providers are advised to submit prior to January 4, 1993, all claims which are submitted according to the instructions in MAPB-092-024-D. Please allow ample mailing time to ensure that claims submitted according to these instructions are received by EDS prior to January 4, 1993. If there is a likely possibility that claims prepared and mailed in late December 1992 will not be received by EDS prior to January 4, 1993, it is to the provider's advantage to submit claims according to the instructions included with this MAPB after January 4, 1993.

Please pay particular attention to the following changes. You are encouraged to review the claim form completion instructions in their entirety, as some additional areas have been reworded to clarify WMAP billing requirements.

A. "Other Insurance" Indicators

The WMAP has reduced the number of allowable "Other Insurance" (OI) codes to simplify billing for providers and increase the accuracy of information received on claims. Claims received on or after January 4, 1993, which do not indicate allowable "OI" codes will be denied. Refer to the HCFA 1500 claim form completion instructions in Attachment 1 of this MAPB for allowable "OI" codes for claims received on or after January 4, 1993.

B. *Medicare Disclaimer Codes*

The WMAP has changed the descriptions of the Medicare disclaimer codes, required in element 11 of the HCFA 1500 claim form, to clarify the correct use of the codes. Refer to the HCFA 1500 claim form completion instructions in Attachment 1 of this MAPB for the new descriptions.

C. *Referring Provider*

The WMAP requests that a referring provider's Unique Physician Identification Number (UPIN) be indicated in element 17A of the HCFA 1500 claim form. If a UPIN number is not available, the referring provider's WMAP individual provider number or license number may be used.

Providers may obtain a UPIN directory from the following address:

Superintendent of Documents
U. S. Government Printing Office
Washington, D.C. 20402
(202) 783-3238

D. *Modifiers*

EDS will be able to process claims which indicate two valid modifiers for each procedure code in the "Modifier" column in element 24D of the HCFA 1500 claim form. Only specific modifiers which are appropriate to the procedure billed are accepted by the WMAP. Allowable WMAP modifiers vary in some cases from those used in the CPT coding structure and by Medicare. Providers should carefully review their MAPBs to make sure they are using only the valid WMAP modifiers for their provider area.

III. ADDITION OF PROCEDURE CODE 70371 FOR SPEECH PATHOLOGISTS AND SPEECH/HEARING CLINICS

Procedure code 70371 (Complex dynamic pharyngeal and speech evaluation by cine or video recording) is a WMAP-covered procedure code for speech pathologists and speech/hearing clinics. When billing for this procedure, providers must indicate type of service (TOS) "4" (Total, i.e., both professional and technical components) or TOS "Q" (Professional Only) in element 24c of the HCFA 1500 claim form. In addition, providers must indicate a referring provider in element 17a of the HCFA 1500 claim form.

IV. SECOND MAJOR HEARING AID REPAIR SERVICE WITHIN 365 DAYS

A. *Prior Authorization Requirement*

Effective with dates of service on or after May 1, 1992, speech/hearing clinics may bill for a second major repair of a hearing aid within 365 days of an original repair if prior authorization has been approved. The second major repair must be performed by the same provider who billed for the first major hearing aid repair.

Providers must submit the PA/ARF1 and PA/ARF2 when requesting prior authorization. Completion of the PA/OF is not required. The provider also must send a copy of the hearing aid performance report documenting the nonfunctioning of the hearing aid.

B. ***Billing for Second Major Hearing Aid Repair Service***

A hearing aid performance report must be completed within 30 days after the recipient receives the repaired hearing aid. The report must be maintained in the provider's records.

When billing for this service, one of the following procedure codes must be used:

Procedure Code	Description
W6950	Standard Hearing Aid Repair, major
W6960	Binaural Hearing Aid Repair, major, right ear
W6961	Binaural Hearing Aid Repair, major, left ear

V. NONCOVERED VERSUS COVERED SERVICES

Providers cannot bill the WMAP for a covered service which is not actually provided and then apply the reimbursement toward the cost of a noncovered service. For example, if a recipient wants a noncovered humidifier, the provider cannot bill the WMAP for a covered humidifier and apply the reimbursement toward the noncovered humidifier.

A provider may provide a noncovered service and bill the recipient separately for the noncovered portion of the service only if the covered and noncovered portions of the service are distinctly separate. In addition, the recipient must be notified in advance and agrees to pay separately for the noncovered portion of the service. For example, a provider may order a covered wheelchair for the recipient and charge the recipient for the noncovered accessories. In this situation, the recipient must have requested the noncovered items and agreed to pay separately for the items.

ATTACHMENT 1

NATIONAL HCFA 1500 CLAIM FORM COMPLETION INSTRUCTIONS FOR THERAPY SERVICES

To avoid denial or inaccurate claim payment, providers must use the following claim form completion instructions. Enter all required data on the claim form in the appropriate element. Do not include attachments unless instructed to do so. All elements are required unless "not required" is specified.

Wisconsin Medical Assistance recipients receive a Medical Assistance identification card upon initial enrollment into the Wisconsin Medical Assistance Program (WMAP) and at the beginning of each month thereafter. Providers should always see this card before rendering services. Please use the information exactly as it appears on the Medical Assistance identification card to complete the patient and insured information.

ELEMENT 1 - PROGRAM BLOCK/CLAIM SORT INDICATOR
Enter claim sort indicator "D" (Durable Medical Equipment), "T" (Therapy Services), or "M" (Rehabilitation Agency) for the service billed in the Medicaid check box. Claims submitted without this indicator are denied.

ELEMENT 1a - INSURED'S I.D. NUMBER
Enter the recipient's ten-digit Medical Assistance identification number as found on the current Medical Assistance identification card. This element must contain no other numbers, unless the claim is a Medicare crossover claim, in which case the recipient's Medicare number may also be indicated.

ELEMENT 2 - PATIENT'S NAME
Enter the recipient's last name, first name, and middle initial as it appears on the current Medical Assistance identification card.

NOTE: A provider may submit claims for an infant if the infant is ten days old or less on the date of service and the mother of the infant is a Medical Assistance recipient. To bill for an infant using the mother's Medical Assistance identification number, enter the mother's last name followed by "Newborn" in element 2. Enter the infant's date of birth in element 3. In element 4 enter the mother's name followed by "Mom" in parentheses. Finally, in element 1A enter the mother's ten-digit Medical Assistance identification number.

ELEMENT 3 - PATIENT'S BIRTH DATE, PATIENT'S SEX
Enter the recipient's birth date in MM/DD/YY format (e.g., February 3, 1955, would be 02/03/55) as it appears on the Medical Assistance identification card. Specify if male or female with an "X."

ELEMENT 4 - INSURED'S NAME (not required)

ELEMENT 5 - PATIENT'S ADDRESS
Enter the complete address of the recipient's place of residence.

ELEMENT 6 - PATIENT RELATIONSHIP TO INSURED (not required)

ELEMENT 7 - INSURED'S ADDRESS (not required)

ELEMENT 8 - PATIENT STATUS (not required)

ELEMENT 9 - OTHER INSURED'S NAME
Third-party insurance (commercial insurance coverage) must be billed prior to billing the WMAP, unless the service does not require third-party billing according to Appendix 18a of Part A of the WMAP Provider Handbook.

- When the provider has not billed other insurance because the "Other Coverage" of the recipient's Medical Assistance identification card is blank, the service does not require third party billing according to Appendix 18a of Part A of the WMAP Provider Handbook, or the recipient's Medical Assistance identification card indicates "DEN" only, this element must be left blank.

- When "Other Coverage" of the recipient's Medical Assistance identification card indicates HPP, BLU, WPS, CHA or OTH, and the service requires third party billing according to Appendix 18a of Part A of the WMAP Provider Handbook, one of the following codes MUST be indicated in the first box of element 9. The description is not required, nor is the policyholder, plan name, group number, etc. (Elements 9a, 9b, 9c and 9d are not required.)

Code	Description
OI-P	PAID in part by other insurance. The amount paid by private insurance to the provider or the insured is indicated on the claim.
OI-D	DENIED by private insurance following submission of a correct and complete claim, or payment was applied towards the coinsurance and deductible. Do NOT use this code unless the claim in question was actually billed to the private insurer.
OI-Y	YES, card indicates other coverage but it was not billed for reasons including, but not limited to: • Recipient denies coverage or will not cooperate; • The provider knows the service in question is noncovered by the carrier. • Insurance failed to respond to initial and follow-up claim; or • Benefits not assignable or cannot get an assignment.

- When "Other Coverage" of the recipient's Medical Assistance identification card indicates "HMO" or "HMP", one of the following disclaimer codes must be indicated, if applicable:

Code	Description
OI-P	PAID by HMO or HMP. The amount paid is indicated on the claim.
OI-H	HMO or HMP does not cover this service or the billed amount does not exceed the coinsurance or deductible amount.

Important Note: The provider may not use OI-H if the HMO or HMP denied payment because an otherwise covered service was not rendered by a designated provider. Services covered by an HMO or HMP are not reimbursable by the WMAP except for the copayment and deductible amounts. Providers who receive a capitation payment from the HMO may not bill the WMAP for services which are included in the capitation payment.

ELEMENT 10 - IS PATIENT'S CONDITION RELATED TO (not required)

ELEMENT 11 - INSURED'S POLICY, GROUP OR FECA NUMBER
The first box of this element is used by the WMAP for Medicare information. (Elements 11a, 11b, 11c, and 11d are not required.) Medicare must be billed for covered services prior to billing the WMAP. When the recipient's Medical Assistance identification card indicates Medicare coverage, but Medicare does not allow any charges, one of the following Medicare disclaimer codes MUST be indicated. The description is not required.

Code	Description
M-1	Medicare benefits exhausted. This disclaimer code may be used by hospitals, nursing homes and home health agencies when Medicare has made payment up to the lifetime limits of its coverage.
M-5	Provider not Medicare certified for the benefits provided.
M-6	Recipient not Medicare eligible.
M-7	Medicare disallowed (denied) payment. Medicare claim cannot be corrected and resubmitted.
M-8	Medicare was not billed because Medicare never covers this service.

If Medicare is not billed because the recipient's Medical Assistance identification card indicated no Medicare coverage, this element must be left blank.

If Medicare allows an amount on the recipient's claim, the Explanation of Medicare Benefits (EOMB) must be attached to the claim and this element must be left blank. Do not enter Medicare paid amounts on the claim form. Refer to Appendix 17 of Part A of the WMAP Provider Handbook for further information regarding the submission of claims for dual entitlees.

ELEMENTS 12 AND 13 - AUTHORIZED PERSON'S SIGNATURE
(Not required since the provider automatically accepts assignment through Medical Assistance certification.)

ELEMENT 14 - DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (not required)

ELEMENT 15 - IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS (not required)

ELEMENT 16 - DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (not required)

ELEMENT 17 - NAME OF REFERRING PHYSICIAN OR OTHER SOURCE
When required, enter the referring or prescribing physician's name.

ELEMENT 17A - I.D. NUMBER OF REFERRING PHYSICIAN
When required, enter the referring provider's six-character UPIN number. If the UPIN number is not available, enter the WMAP provider number of license number of the referring provider.

ELEMENT 18 - HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (not required)

ELEMENT 19 - RESERVED FOR LOCAL USE
If an unlisted procedure code is billed, providers may describe the procedure in this element. If there is not enough space for the description, or if multiple unlisted procedure codes are being billed, providers must attach documentation to the claim describing the procedure(s). In this instance, providers must indicate "See Attachment" in element 19.

ELEMENT 20 - OUTSIDE LAB
If laboratory handling fees are billed, check either "yes" or "no" to indicate whether an outside lab was used.

ELEMENT 21 - DIAGNOSIS OR NATURE OF ILLNESS OR INJURY
The International Classification of Disease (ICD) diagnosis code must be entered for each symptom or condition related to the services provided. Manifestation ("M") codes are not acceptable. List the primary diagnosis first. Etiology ("E") codes may not be used as a primary diagnosis. The diagnosis description is not required.

ELEMENT 22 - MEDICAID RESUBMISSION (not required)

ELEMENT 23 - PRIOR AUTHORIZATION
Enter the seven-digit prior authorization number from the approved prior authorization request form. Services authorized under multiple prior authorizations must be billed on separate claim forms with their respective prior authorization numbers.

ELEMENT 24A - DATE(S) OF SERVICE
Enter the month, day, and year for each procedure using the following guidelines:

- When billing for one date of service, enter the date in MM/DD/YY format in the "From" field.
- When billing for two, three, or four dates of service on the same line, enter the first date of service in MM/DD/YY format in the "From" field, and subsequent dates of service in the "To" field by listing only the date(s) of the month (i.e., DD, DD/DD, or DD/DD/DD).

It is allowable to enter up to four dates of service per line if:

-- All dates of service are in the same calendar month.

-- All services are billed using the same procedure code and modifier, if applicable.

-- All procedures have the same type of service code.

-- All procedures have the same place of service code.

-- All procedures were performed by the same provider.

-- The same diagnosis is applicable for each procedure.

-- The charge for each procedure is identical. (Enter the total charge per detail line in element 24F.)

-- The number of services performed on each date of service is identical.

-- All procedures have the same HealthCheck or family planning indicator.

– All procedures have the same emergency indicator.

ELEMENT 24B - PLACE OF SERVICE
Enter the appropriate WMAP single-digit place of service code for each service.

Numeric	Description
3	Office
4	Home
7	Nursing Home
8	Skilled Nursing Facility

ELEMENT 24C - TYPE OF SERVICE CODE
Enter the appropriate single-digit type of service code.

Numeric	Description
1	Medical (including: Injection, Physician's Medical Services, Home Health, Independent Nurses, Audiology, PT, OT, ST, Personal Care, Medical Day Treatment)
4	Total (i.e., both professional and technical components)
9	Other Services, including: Rehabilitation Agency

Alpha	Description
P	Purchase New DME
Q	Professional Only
R	DME Rental

ELEMENT 24D - PROCEDURES, SERVICES, OR SUPPLIES
Enter the appropriate five-character procedure code and, if applicable, a maximum of two, two-character modifiers. Refer to MAPB-092-027-D, MAPB-087-016-D, MAPB-087-014-D, and MAPB-087-013-D for a list of allowable procedure codes.

ELEMENT 24E - DIAGNOSIS CODE
When multiple procedures related to different diagnoses are submitted, column E must be used to relate the procedure performed (element 24D) to a specific diagnosis in element 21. Enter the number (1, 2, 3, or 4) which corresponds to the appropriate diagnosis in element 21.

ELEMENT 24F - CHARGES
Enter the total charge for each line.

ELEMENT 24G - DAYS OR UNITS
Enter the total number of services billed for each line. A decimal must be indicated when a fraction of a whole unit is billed. For a hearing aid rental service, the total number of days the item was rented should be entered as the quantity. This must coincide with the date range indicated. For hearing aid batteries, enter the number of batteries.

ELEMENT 24H - EPSDT/FAMILY PLANNING
Enter an "H" for each procedure that was performed as a result of a HealthCheck (EPSDT) referral. Enter an "F" for each family planning procedure. Enter a "B" if BOTH HealthCheck and family planning services were provided. If HealthCheck/family planning do not apply, leave this element blank.

ELEMENT 24I - EMG
Enter an "E" for each procedure performed as an emergency, regardless of the place of service.

ELEMENT 24J - COB (not required)

ELEMENT 24K - RESERVED FOR LOCAL USE
Enter the eight-digit, Medical Assistance provider number of the performing provider for each procedure, if it is different than the billing provider number indicated in element 33.

When applicable, enter the word "spenddown" and under it, the spenddown amount on the last detail line of element 24K directly above element 30. Refer to Section IX of Part A of the WMAP Provider Handbook for information on recipient spenddown.

Any other information entered in this column may cause claim denial.

ELEMENT 25 - FEDERAL TAX ID NUMBER (not required)

ELEMENT 26 - PATIENT'S ACCOUNT NO.
Optional - provider may enter up to 12 characters of the patient's internal office account number. This number will appear on the EDS Remittance and Status Report.

ELEMENT 27 - ACCEPT ASSIGNMENT
(Not required, provider automatically accepts assignment through Medical Assistance certification.)

ELEMENT 28 - TOTAL CHARGE
Enter the total charges for this claim.

ELEMENT 29 - AMOUNT PAID
Enter the amount paid by other insurance. If the other insurance denied the claim, enter $0.00. (If a dollar amount is indicated in element 29, "OI-P" must be indicated in element 9.)

ELEMENT 30 - BALANCE DUE
Enter the balance due as determined by subtracting the recipient spenddown amount in element 24K and the amount paid in element 29 from the amount in element 28.

ELEMENT 31 - SIGNATURE OF PHYSICIAN OR SUPPLIER
The provider or the authorized representative must sign in element 31. The month, day, and year the form is signed must also be entered in MM/DD/YY format.

> NOTE: This may be a computer-printed or typed name and date, or a signature stamp with the date.

ELEMENT 32 - NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED
If the services were provided to a recipient in a nursing home (place of service 7 or 8), indicate the nursing home's eight-digit Medical Assistance provider number.

ELEMENT 33 - PHYSICIAN'S, SUPPLIERS BILLING NAME, ADDRESS, ZIP CODE, AND PHONE NUMBER

Enter the provider's name (exactly as indicated on the provider's notification of certification letter) and address of the billing provider. At the bottom of element 33, enter the billing provider's eight-digit Medical Assistance provider number.